

CIRCUIT COURT CLERK  
D.C.

**IN THE CIRCUIT COURT OF TENNESSEE  
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS, SHELBY COUNTY**

**Tracy Lynn Fulton**  
**Plaintiff**

v.

**West Coast Life Insurance Co.**  
**Defendant**

No.: CT-005664-01

Div.: V

**JURY DEMAND**

**COMPLAINT**

**TO THE HONORABLE JUDGES OF THE CIRCUIT COURT OF SHELBY  
COUNTY, TENNESSEE**

Comes plaintiff, Tracy Lynn Fulton, Individually and as Administratrix of the Estate of David C. Fulton, by and through her lawyers, Rieves, Rubens & Mayton, and for her complaint against defendant West Coast Life Insurance Co., states:

1. Plaintiff, Tracy Lynn Fulton ("Fulton") is a resident of the State of Tennessee, and resides at 4955 Shaws Ridge Trail, Arlington, Tennessee.
2. Defendant, West Coast Life Insurance Co. ("West Coast") is a California insurance company, licensed to conduct business in the State of Tennessee. The address of the offices of West Coast is P.O. Box 193892, San Francisco, CA 94119. West Coast's agent for service of process, pursuant to T.C.A. § 56-2-103, is the Commissioner of the Tennessee Department of Commerce and Insurance, Attn: Service of Process, 500 James Robertson Parkway, Nashville, Tennessee 37243-1131.

3. This court has jurisdiction over the parties and the subject matter and venue is appropriate in Shelby County, Tennessee.

4. On or about April 4, 2008, plaintiff's spouse, David C. Fulton ("David Fulton"), contracted with defendant to provide an insurance policy on David Fulton's life, under policy number Z06035140, with plaintiff as designated beneficiary. A copy of the "Conditional Receipt Agreement" and application for life insurance, signed by West Coast's agent and David Fulton are attached hereto as Exhibit "A" and incorporated herein by reference thereto.

5. The aforementioned life insurance policy applied for by David Fulton was a standard, non-smoking policy with a payable benefit of \$500,000.00, for which David Fulton paid a premium of Five Hundred Eleven Dollars (\$511.00).

6. David Fulton ceased using tobacco products of any kind during September of 2006. On his insurance application for the aforementioned policy, David Fulton indicated that he had not smoked cigarettes since September of 2006.

7. As part of the application process for the above mentioned insurance policy, David Fulton was required to submit to a blood screening and medical examination. Testing of the blood and urine samples drawn from David Fulton was completed on April 17, 2008.

8. Defendant West Coast received the aforementioned Conditional Receipt Agreement, along with the application for life insurance, the medical screening report, and the premium payment of \$511.00 on or about April 22, 2008.

9. David Fulton died on May 16, 2008, at the age of 51 years, after suffering a myocardial infarction (heart attack).

10. On or about May 16, 2008, defendant was notified of David Fulton's death, and a claim was made against the aforementioned life insurance policy.

11. On or about September 9, 2008, which is more than one hundred (100) days after receiving the aforementioned Conditional Receipt Agreement, application, medical report, and premium payment, and more than ninety (90) days after the claim was made, defendant denied payment under the aforementioned life insurance policy, claiming that David Fulton's urinalysis indicated a minute presence of cotinine.

12. Without waiving their claim that David Fulton did not use tobacco products at the time he contracted for the above insurance, plaintiff alleges that defendants knew or should have known of the results of the urine test prior to the death of David Fulton, yet defendant did not notify David Fulton that he would not be approved at a non-smoking rate, and could opt for a policy with a smoking rate; but instead, defendant accepted the payment from David Fulton in the amount of Five Hundred Eleven Dollars (\$511.00). It was not until after David Fulton's death, and the submission of a claim for benefits that defendant made the decision to deny coverage.

13. Defendant's denial of benefits as stated above constitutes a bad faith refusal to pay pursuant to T.C.A. § 56-7-105, for which plaintiff has suffered additional damages, including attorney fees, court costs and other damages not yet determined.

**WHEREFORE, PREMISES CONSIDERED,** plaintiff prays that:

1. A jury be empaneled to determine all issues of fact;
2. She be awarded judgment against defendants in the amount of Five Hundred Thousand Dollars (\$500,000.00);

3. She be awarded additional damages in an amount as yet undetermined for defendant's bad faith refusal to pay benefits under the above policy of insurance;
4. She be awarded a reasonable fee for her attorneys and for costs herein incurred;
5. She be awarded any and all further relief to which she may be entitled;
6. Plaintiff reserves the right to amend her complaint as necessary.

Respectfully submitted,

TRACY LYNN FULTON

By: 

Michael D. Snell (BPR # 026020)  
Brian F. Walthart (BPR # 024777)  
Rieves, Rubens & Mayton  
P.O. Box 1359  
West Memphis, AR 72303  
(870) 735-3420

# West Coast Life Insurance Company

A PROTECTIVE COMPANY

343 Sansome Street, San Francisco, CA 94104  
PO Box 193892, San Francisco, CA 94119-3892  
1-800-368-9378

## Conditional Receipt Agreement \*

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this Agreement are met. No Agent of the Company can alter or waive any of the provisions of this Agreement. No insurance is provided under the terms of this document in the event of death of the insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☒ Check in the amount of \$ 511.00 for an amount equal to the premium due on the policy applied for, or ☐ Check-O-Matic Plan (COM), as conditional payment of the first premiums for an insurance policy on the life of

Proposed Insured(s) Daniel C. Fulton

An application for life insurance on each person proposed for insurance is being made today to West Coast Life Insurance Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO WEST COAST LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any other in force life insurance and accidental death benefits, including those applied for, with this Company on this insured exceeds \$1,000,000 net amount at risk or on Proposed insureds under 15 days of age or over age 65.

## CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

- Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:
- (A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's printed underwriting rules for the plan, amount and premium rate class applied for;
  - (B) that the amount paid with the application and shown above is equal to the first full modal premium for the premium rate class applied for;
  - (C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company; and
  - (D) As of the effective date, the state of health and all factors affecting the insurability of each person proposed for insurance must be as stated in the application.

## EFFECTIVE DATE OF COVERAGE

If the above conditions are met, Insurance provided under this Agreement shall take effect on the latest of:

- (A) the date of the application;
- (B) the date requested in the application; or
- (C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

## AMOUNT OF COVERAGE

The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed the amount of initial premium plus \$1,000,000. This amount includes other life insurance and accidental death benefits then in force or applied for with this Company.

## TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

- (A) premium payment is
  - (1) by check, and it is not honored by the drawee bank upon presentation;
  - (2) by COM, and the deduction is not honored by the drawee bank;
- (B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety business days from its date.

The Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by West Coast Life.

Date: 4/14/08

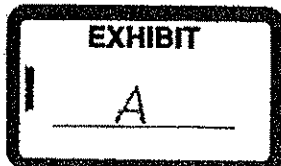
Agent: [Signature]

Date: 4/14/08

Applicant/Owner: [Signature]

Home Office Copy

W 7705(7/05)  
(12/06)



\* NOT FOR USE IN ALABAMA, PENNSYLVANIA AND VERMONT.

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# West Coast Life Insurance Company

A PROTECTIVE COMPANY

P.O. Box 103802

San Francisco, CA 94119-3892

## LIFE INSURANCE APPLICATION

Part I

## SECTION I: INSURED

NAME OF PERSONS APPLYING FOR COVERAGE (PRINT IN FULL)	RELATIONSHIP TO PROPOSED INSURED	SEX	DATE OF BIRTH	SOC. SEC. NO.	BIRTH STATE	DRIVER'S LICENSE NUMBER
David C. Fulton	Self	M	1-25-1957	987-66-3208	MO	45036502 TD
CHILD						
CHILD						

RESIDENCE: 4955 Shaws Ridge Trail

Arlington

STREET

TN

STATE

38002

ZIP CODE

APT. NO.

901/867-7066

TELEPHONE NUMBER

6m.

NUMBER OF YEARS

OCCUPATION	# OF YRS	(Required) ANNUAL INCOME	EMPLOYER	ADDRESS	TELEPHONE NUMBER
PROPOSED INSURED'S OCCUPATION Bus Owner	9yrs	\$9,000	Power Express	3875 South Meridian Hall Memphis, TN 38115	901/867-7066
SPOUSE'S OCCUPATION					

## SECTION II: PLAN OF INSURANCE

FACE AMOUNT \$ 500,000

INSURED

\$

SPOUSE

\$

CHILDREN

PLAN OF INSURANCE Focus 20

NAME OF PRODUCT

IF UNIVERSAL LIFE: ☒ OPTION I - LEVEL FACE AMOUNT☐ OPTION II - FACE AMOUNT PLUS CASH VALUEIF TERM INDICATE YEARS: ☐ 10 YRS☐ 15 YRS☒ 20 YRS☐ 25 YRS☐ 30 YRS

## BENEFITS

☐ AUTOMATIC PREMIUM LOAN☐ ACCIDENTAL DEATH \$☐ WAIVER OF PREMIUM☐ CHILD RIDER - # OF UNITS☐ OTHER - DESCRIPTION AND AMOUNT

## PREMIUM PAYMENT

☐ ANNUAL \$☐ CHECK-O-MATIC \$☒ OTHER \$11<sup>00</sup> Quarterly☐ ADDITIONAL FIRST YEAR PAYMENT \$☐ CASH WITH APPLICATION \$ 511<sup>00</sup>SEND PREMIUM NOTICES TO ☐ RESIDENCE☒ OTHER - COMPLETE LINE BELOW

Power Express 3875 South Meridian Hall

Name

Address

City

State

38115

Zip Code

## SECTION III: BENEFICIARY

PRIMARY: FULL NAME Tracy Fulton

4955 Shaws Ridge Trail

ADDRESS

CITY

Arlington

STATE

TN

ZIP CODE

38002

SECONDARY: FULL NAME

RELATIONSHIP



**SECTION IV: NON-MEDICAL HISTORY (MUST BE ANSWERED FOR ALL PROPOSED INSURED)**

Part I

HAS PROPOSED INSURED:		Prop. Ins.		Spouse		Children	
		Yes	No	Yes	No	Yes	No
1. Used tobacco or nicotine of any kind over the last 5 years? Type: <u>Cigarette</u> Frequency: <u>1/2 pack/day</u> Date last used: <u>7/2006</u>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol? B. Narcotics, stimulants, sedatives, hallucinogenic drugs?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Flown as a pilot, student pilot, or crew member, or intend to fly as such?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? If 'Yes', please list: branch of service, rank, duties, mobilization category and current duty station.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Engaged in auto, motorcycle or boat racing, parachuting, skin or scuba diving, skydiving, or hang gliding or other hazardous avocation or hobby?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Any application for any other life or health insurance on your life now pending or contemplated in this or any other company?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is there an intention that any party, other than the owner, will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is Proposed Insured: a). A citizen of any other country besides U.S.? If so, what country? b). Have you lived outside of North America at any time during the last 3 years? c). Intending to travel outside the United States or Canada within the next 12 months? To where: _____ When: _____ Why: _____ For how long: _____		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION V: MEDICAL HISTORY**

HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAD:		Prop. Ins.		Spouse		Children	
		Yes	No	Yes	No	Yes	No
12. A. Cancer, diabetes, epilepsy, heart disorder, high blood pressure, stroke, mental or nervous disorders, tumors, ulcers, or any disorder of bladder, kidney, liver or lungs? B. AIDS (acquired immune deficiency syndrome) or ARC (AIDS-related complex)? C. Arthritis, gout, or other disorders of muscles, joints, spine, stomach, intestines, or chest pain or asthma?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Within the last 12 months, had any kind of medication prescribed?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Been advised to have, or contemplated having a surgical operation?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. List current height and weight for all persons proposed for coverage. If more than one child proposed for insurance, list below		Height Weight					
		<u>6'2"</u> <u>210</u>					

**SECTION VI: DETAILS TO ANY "YES" ANSWERS TO QUESTIONS #1 THROUGH #15 ABOVE (MUST BE ANSWERED IF APPLICABLE)**

Person's Name	Question Number	Date	Details or Reason	Name, Address and Phone Number of Attending Doctor and Hospital

Part I

**SECTION VII: EXISTING COVERAGE AND PENDING INSURANCE**  
(MUST BE ANSWERED COMPLETELY ON ALL CASES)

17. Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life. Please be sure to include insurance whether owned by the insured or not. If "none" please state it below.

Name of Insured	Company	Type of Coverage	Life Amount	Business or Personal	Year Issued
		<i>N/A</i>			

**SECTION VIII: REPLACEMENT** (MUST BE ANSWERED COMPLETELY ON ALL CASES)18. Is the policy applied for to replace an existing insurance or annuity policies in this or any other company Yes ☐ No ☒  
If "yes," give details in remarks section and complete any State required replacement forms and comparison statements.

Home Office Endorsements:

**SECTION IX: OWNERSHIP OF POLICY**

NAME OF OWNER (If other than proposed insured)

SOCIAL SECURITY NO. OR TAXPAYER I.D. NO.

ADDRESS

CITY

STATE

ZIP CODE

**SECTION X: BUSINESS INSURANCE**

a. Purpose of Insurance (Key Person, Buy &amp; Sell, Split Dollar, etc.)

b. What percent of business does Proposed Insured own or control?

c. What is approximate net annual income of business?

d. What is approximate net worth of business?

e. Year business established

f. Business Insurance on other Owners, Officers, Partners, or Key Persons

Name and Title	% of Business Owned	Insurance Company	Amount Now Carried or Applied for
			\$
			\$
			\$

**SECTION XI: REMARKS AND SPECIAL REQUESTS**



Part I

**DECLARATIONS**

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

1. All such statements and answers shall be the bases for and a part of any policy issued on this application.
2. No agent or medical examiner can accept risks or make or change contracts or waive West Coast Life rights or requirements.
3. No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full first premium is paid. However, if the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.
4. Acceptance of a policy by the Owner shall constitute ratification of any changes made by West Coast Life under "Home Office Endorsements." In those states where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

**AUTHORIZATION TO OBTAIN INFORMATION**

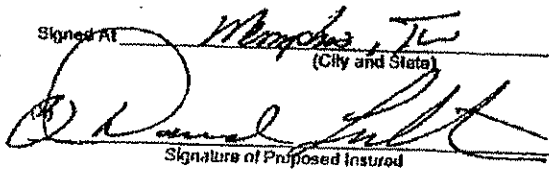
I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or consulting company, the Medical Information Bureau, Inc., consumer reporting agencies or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information about me or my minor children to give West Coast Life Insurance Company, its affiliates, its reinsurers, or persons or organizations providing services for West Coast Life any and all such information. This includes information regarding drugs, alcoholism, and/or mental illness. To aid in collection of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Insurance Company to collect and transmit such information. I AUTHORIZE the Company to obtain an investigative consumer report with respect to me and with respect to any children proposed for insurance. If a report is requested, I know I may elect to be personally interviewed. I UNDERSTAND the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by West Coast Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or a claim or as may be otherwise lawfully required or as I may further authorize. I AGREE that this authorization shall be valid for a period of two years and six months from the date signed. I further agree that a photocopy of this authorization shall be as valid as the original. I KNOW that I may ask to receive a copy of this authorization. I HAVE received copies of notices regarding "Pre-Notice Medical Information Bureau, Inc." and "Insurance Information Practices and Investigative Consumer Reports." I UNDERSTAND that if this application relates to any Indeterminate Premium Policy or Rider: (1) The premium may be increased or decreased on any policy anniversary. (2) Premiums are not guaranteed, except the maximum premium which may be charged beginning on any policy anniversary. (3) Any increased or decreased premium I am charged will be based on my original classification, age and sex.

Signed At

(City and State)

Date

4/4/08

  
Signature of Proposed Insured

(X)

Signature of Spouse, if Proposed for Insurance

(X)

Signature of Owner, if Other than Proposed Insured

(X)

Signature of Agent

**SECTION XII: AGENT'S REPORT**

I CERTIFY THAT: (1) THE ANSWERS GIVEN IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF; (2) I KNOW OF NOTHING AFFECTING THE RISK WHICH IS NOT SET FORTH IN MY AGENT'S CONTRACT OR THIS LIFE INSURANCE APPLICATION; AND (3) I CAREFULLY EXPLAINED EACH QUESTION BEFORE RECORDING EACH ANSWER AND BEFORE THE APPLICATION WAS SIGNED.

1. Do you understand that no final underwriting offer is valid unless a policy has been issued and delivered? Yes ☒ No ☐
2. How long have you known insured? 3 Years        Months
3. Is insured a relative or does the insured have a business relationship with you? Yes ☐ No ☒
4. Does proposed insured appear healthy and free from visible or known impairments or disability? Yes ☒ No ☐
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? Yes ☐ No ☒  
If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.
6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? Yes ☐ No ☒
7. Is Premium Financing involved in this case? Yes ☐ No ☒  
If YES, please submit a cover letter describing the parameters.
8. Family History

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?	Cancer History?	Type
Father		57	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, age of onset <u>      </u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, age of onset <u>57</u> If Yes, date of onset <u>      </u>	Lung
Mother		81	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, age of onset <u>      </u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, age of onset <u>81</u> If Yes, date of onset <u>      </u>	Lung
Siblings			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset <u>      </u>	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset <u>      </u> If Yes, date of onset <u>      </u>	

## 9. INDICATE CLASSIFICATION BASIS FOR THIS SALE:

- ☐ Super Preferred  
☐ Preferred  
☒ Standard  
☐ Rated Table A, B, C, D, E, F, H (circle one)  
☐ Other

☒ Non-Tobacco  
☐ Tobacco

<b>BISYS</b> BGA Name <u>NO810</u> BGA Contract Number	For Underwriting and New Business Contact Purposes: <u>717-703-4913</u> BGA Fax Number <u>DOBIS Castle 10220010154</u> BGA E-Mail Address
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SYS Insurance Services, Inc.  
 401 Carner Executive Park  
 Suite 320  
 Charlotte, NC 28226  
 88-852-3727

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.)  
 Identification type: 95036502 TN  
 Please include Driver's License number if Owner is other than the Proposed Insured.  
 In Georgia, please include a copy of the Driver's License with application.

Agent's Signature <u>[Signature]</u> Agent's Printed Name <u>GARY S. DEBENB</u> Agent's Commission Code No. <u>GG493</u> Agent's E-Mail Address <u>      </u>	Business Phone <u>901/882-3277</u> Date <u>4/14/08</u> Place <u>Memphis, TN</u>
IF MORE THAN ONE AGENT - complete below Agent's Signature <u>[Signature]</u> Agent's Printed Name <u>Brett Catcher</u> Agent's Commission Code No. <u>HF878</u> Agent's E-Mail Address <u>      </u>	Business Phone <u>901/321-1000</u> Date <u>4/9/08</u> Place <u>Memphis, TN</u>

**IMPORTANT NOTICES**

**MUST BE GIVEN TO THE PROPOSED INSURED**

**PRE-NOTICE MEDICAL INFORMATION BUREAU, INC.**

Information regarding your insurability will be treated as confidential. The West Coast Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-892-8901 (TTY 866-348-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

The West Coast Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**INSURANCE INFORMATION PRACTICES AND INVESTIGATIVE CONSUMER REPORTS NOTICE**

Thank you for your application. To assure that each insured's premium and coverage is properly related to the probability of loss, we must underwrite your application.

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

To underwrite your application, we need to obtain information about you. Some of that information will come from you and some will come from other sources.

As part of this process, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics and mode of living. This information may be retained by the insurance support organization and disclosed to other persons.

If an investigative consumer report is requested in connection with your application, you have the right to elect to be interviewed. You also have the right to access and to correct any information collected except information which is related to a claim or civil or criminal proceeding. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

It is also possible that we may call you to verify information or to ask additional questions important to the underwriting of your application. After this telephone interview is completed, a copy of it will be sent to you so you can verify its accuracy.

If you wish to have a more detailed explanation of our information practices, please submit a written inquiry to: Chief Underwriter, Underwriting Department, West Coast Life Insurance Company, P.O. Box 193892, San Francisco, CA 94119-3892.

**PRODUCER COMPENSATION DISCLOSURE**

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product of insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.



RECEIVED

DEC 29 2008

LEGAL DEPT.

RECEIVED

DEC 29 2008

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CLERK

STATE OF TENNESSEE  
DEPARTMENT OF COMMERCE AND INSURANCE  
500 JAMES ROBERTSON PARKWAY  
NASHVILLE, TN 37243-1131

December 19, 2008

West Coast Life Insurance Company  
P O Box 193892  
San Francisco, CA 94119  
NAIC # 70335

CERTIFIED MAIL  
RETURN RECEIPT REQUESTED  
7008 1140 0002 5991 8847  
Cashier # 6743

Re: Tracy Lynn Fulton V. West Coast Life Insurance Company

Docket # CT-005664-08

To Whom It May Concern:

We are enclosing herewith a document that has been served on this department on your behalf in connection with the above-styled matter.

I hereby make oath that the attached Breach Of Contract Complaint was served on me on December 17, 2008 by Tracy Lynn Fulton pursuant to Tenn. Code Ann. § 56-2-504 or § 56-2-506. A copy of this document is being sent to the Circuit Court of Shelby County, TN.

Brenda C. Meade  
Designated Agent  
Service of Process

Enclosures

cc: Circuit Court Clerk  
Shelby County  
140 Adams Street, Rm 324  
Memphis, Tn 38103

EC-51626

## Rieves, Rubens & Mayton

### LAWYERS

West Memphis Office  
304 East Broadway  
P.O. Box 1359  
West Memphis, AR 72303  
Telephone 870-735-3420  
Telecopier 870-735-4678

Elton A. Rieves III  
Kent J. Rubens  
Lawrence W. Jackson  
Brian F. Walthart\*\*  
Michael D. Snell\*\*

Of Counsel:  
A.C. Hooper\*\*

Elton A. Rieves, Jr.  
(1909-1984)  
Edward J. Rubens  
(1913-1977)  
Ralph W. Sloan  
(1915-1996)  
Elton A. Rieves, IV  
(1957-2005)

Little Rock Office  
Suite 200, The Lion Building  
401 West Capitol Avenue  
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Michael R. Mayton\*  
Eric Newkirk  
David C. Jones  
Michael C. Stiles  
Michael N. Harry

Also Licensed In Texas\*  
Licensed Also In Tennessee\*\*

December 10, 2008

**VIA CERTIFIED MAIL  
RESTRICTED DELIVERY  
RETURN RECEIPT REQUESTED**

Commissioner of the Tennessee  
Department of Commerce & Insurance  
Attn: Service of Process  
500 James Robertson Parkway  
Nashville, TN 37243-1131

Re: Tracy Lynn Fulton v. West Coast Life  
Insurance Company  
Case No. CT-005664-08

To Whom it May Concern:

Pursuant to the provisions of the Tennessee Rules of Civil Procedure, and the statutes of the State of Tennessee enclosed is a copy of the complaint, in the above-captioned matter, together with a copy of the summons issued therein. I have also enclosed our check in the amount of \$15.00 for the service fee.

You are warned that upon your failure to answer said complaint on or before the first day after thirty days after the service of this summons and complaint upon you, that the same will be taken for confessed and judgment by default rendered.

Very truly yours,

RIEVES, RUBENS & MAYTON

*Michael D. Snell*  
(pm)

Michael D. Snell

MDS/bm  
Enclosures



**(CHANCERY/CIRCUIT) COURT OF TENNESSEE  
140 ADAMS AVENUE MEMPHIS, TENNESSEE 38103  
FOR THE THIRTIETH JUDICIAL DISTRICT AT MEMPHIS**

**SUMMONS IN CIVIL ACTION**

NO. CT-05164-08 DNV AD DAMNUM \$500,000.00 AUTO ☐ OTHER ☒  
 Tracy Lynn Fulton 4955 Shaws Ridge Trail, Arlington, TN 38002  
 Home Address  
 vs. PLAINTIFF Business Address  
 West Coast Life Insurance Co. Home Address  
 P.O. Box 193892, San Francisco, CA 94119  
 DEFENDANT Business Address  
 TO THE DEFENDANT(S): West Coast Life Insurance Company

You are hereby summoned and required to defend a civil action by filing your answer with the Clerk of the Court and serving a copy of your answer to the Complaint on Michael D. Snell (Rieves, Rubens & Mayton) Plaintiff's attorney, whose address is P.O. Box 1359, West Memphis, AR 72303, telephone (870) 735-3420 within THIRTY (30) DAYS after this summons has been served upon you, not including the day of service. If you fail to do so, a judgment by default may be taken against you for the relief demanded in the Complaint.

JIMMY MOORE, Clerk  
KENNY ARMSTRONG, Clerk & Master

TESTED AND ISSUED 11/24, 2008 By [Signature], D.C.

TO THE DEFENDANT(S):

NOTICE: Pursuant to Chapter 919 of the Public Acts of 1980, you are hereby given the following notice: Tennessee law provides a four thousand dollar (\$4,000) personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed. These include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

**COST BOND**

I hereby acknowledge and bind myself for the prosecution of this action and payment of all costs not to exceed \$500.00 in this court which may at any time be adjudged against the plaintiff in the event said plaintiff shall not pay the same.

Witness My Hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Certification when applicable

I, KENNY ARMSTRONG, Clerk & Master of the Chancery Court, Shelby County, Tennessee, certify this to be a true and accurate copy as filed this \_\_\_\_\_  
 KENNY ARMSTRONG, Clerk & Master

By: \_\_\_\_\_, D.C.

Surety

I, JIMMY MOORE, Clerk of the Circuit Court, Shelby County, Tennessee, certify this to be a true and accurate copy as filed this 11/24/08  
 JIMMY MOORE, Clerk

By: [Signature], D.C.



**RETURN ON SERVICE OF SUMMONS**

I HEREBY CERTIFY THAT I HAVE SERVED THE WITHIN SUMMONS:

By delivering on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ M.  
a copy of the summons and a copy of the Complaint to the following defendants\_\_\_\_\_  
Mark Luttrell, SheriffBy \_\_\_\_\_  
Deputy Sheriff**PRIVATE PROCESS SERVER**

I HEREBY CERTIFY THAT I HAVE SERVED THE WITHIN SUMMONS:

By delivering on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ M. a copy of the  
summons and a copy of the Complaint to the following defendants

(PLEASE PRINT THE FOLLOWING)

\_\_\_\_\_  
Private Process Server\_\_\_\_\_  
Address\_\_\_\_\_  
Phone\_\_\_\_\_  
Company\_\_\_\_\_  
Signature\_\_\_\_\_  
Other manner of service:

I hereby certify that I have NOT served this Summons on the within named defendant(s) \_\_\_\_\_

because \_\_\_\_\_ is / are not to be found in this County for the  
following reason(s): \_\_\_\_\_\_\_\_\_\_  
Mark Luttrell, SheriffThis \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ By \_\_\_\_\_  
Deputy SheriffNO. 09-5664-D. 2IN THE  
(CHANCERY/CIRCUIT)  
COURT  
OF TENNESSEE  
FOR THE THIRTIETH  
JUDICIAL DISTRICT AT MEMPHIS

SUMMONS IN CIVIL ACTIONS

PLAINTIFF

VS.

DEFENDANT

Came to hand \_\_\_\_\_

Attorney for Plaintiff

Tel. No. \_\_\_\_\_

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